

2020-21 employee benefits guide



If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please refer to your Medicare Part D Non-Creditable Coverage Notice on pages 47 & 48 of this guide for more details.

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Your Health is Important!

The City of Killeen wants to provide you with the freedom to select quality benefit options that work best for you.

It is important that you take an opportunity to review all of your plan options in detail. You will need to carefully consider each benefit option, its cost and value to you, and whether it is appropriate for your personal need. By taking the time to examine all of your options, you will ensure that your benefits meet those needs throughout the plan year.

The City of Killeen values our employees and recognizes the importance of offering benefits that enhance people's lives. Benefits elections are effective October 1, 2020.

Medical/Rx Plans – United Health Care will provide access to two (2) medical/RX plans from which employees may select.

Lincoln Financial Group – Dental; Term Life and Accidental Death and Dismemberment; Accident; Critical Illness; Voluntary Term Life and Accidental Death and Dismemberment; Short Term Disability; Long Term Disability

Guardian – Cancer and Vision

Combined Worksite Solutions - Lifetime Benefit Term (Long Term Care)

Texas Life - Life insurance offering

Benefit Resources

BENEFIT	CARRIER	MEMBER SERVICES #	WEBSITE ADDRESS
Plan I (HDHP w/HSA) - Medical Plan II (Co-Pay) - Medical	United Health Care	1-866-414-1959	www.myuhc.com
Pharmacy	United Health Care	1-866-414-1959	www.myuhc.com
Dental	Lincoln Financial	800-423-2765	www.lincolnfinancial.com
Basic Life/AD&D	Lincoln Financial	800-348-4512	www.lincolnfinancial.com
Worksite – Voluntary Life/AD&D Critical Illness Accident Short Term Disability Long Term Disability	Lincoln Financial	800-423-2765	www.lincolnfinancial.com
Cancer	Guardian	888-600-1600	www.guardianlife.com
EmployeeConnect SM (Employee Assistance Program)	Lincoln Financial	888-628-4824	www.GuidanceResources.com
Vision	Guardian	844-557-2646	www.GuardianAnytime.com
Long Term Care	Combined	800-490-1322	www.combinedinsurance.com
Flexible Spending Accounts	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Health Savings Plan	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Human Resources	City of Killeen	254-501-7837	www.killeentexas.gov
Benefit Website	Web Benefits Design	800-779-8952	www.mybensite.com/Killeen



Employee Benefits Website and Enrollment Instructions

Welcome to the City of Killeen employee benefits website! As you know, your benefits are an important part of your overall compensation. The City of Killeen is proud of our simple, convenient, online benefits enrollment system that makes enrollment faster and easier than ever before! Please visit our employee benefits website to register:

www.mybensite.com/killeen

New User: Once you've gained access to the site, you will be asked to register as a user on the system by creating a new user account. When creating a new user account, you must enter your last name, DOB, email address, and last 4 of SSN. You will also be asked to select a password. Once that has been completed, you will be logged into the website and gain access to the enrollment system.

Current User: Gain access to the website. Once you have gained access, you will log in with the email address and password you selected when you created a new user account. If you cannot remember your password, click on the "Forgot Password" to create a new password.

Inside the website you will find important information such as benefit summaries, forms, summary plan descriptions, provider search directories, frequently asked questions, and much more. Please review this information thoroughly before entering the Enrollment section of the website; it is important that you know and understand your benefit options BEFORE starting the enrollment process.

Please make sure your spouse is aware of this valuable resource. By providing you with this comprehensive benefits website, we want to emphasize the significant investment we are making in you. We encourage you to take advantage of all the programs and opportunities we offer.

Before You Begin:

- Please review the plan information available on this benefits website. All benefit summaries, Summary Plan Description (SPDs) and FAQs are accessible for all lines of coverage.
- If you are enrolling your spouse and/or children, please have their dates of birth and social security numbers.



Getting Started:

- To begin, fill in your personal information under "Create Account" if you are a new user, or, if you have already registered, simply fill in your email address and password under "Employee Log In".
- Once you have registered, you can access the website or continue to the online enrollment site.

If you need assistance with your enrollment, please contact Human Resources – COK-Benefits@killeentexas.gov.

Enrollment has never been easier!

Once inside the site, you will go through a series of screens – each screen takes only a few moments to complete. All of your benefit elections will be displayed on a cost “per paycheck” basis reflecting your specific benefit options.

- 1) **Personal Information:** Please verify that all the information is accurate. If you see any blank fields or need to make changes, please update the information on this screen.
- 2) **Dependent Information:** If you have a spouse or children that you wish to cover, please enter their information in this section. Remember that you will need correct names, dates of birth, and social security numbers for all covered individuals.
- 3) **Benefit Selections:** The next few screens will present benefits selections by product (medical, dental, vision, life insurance, disability, etc.). Each page will show you the benefits you are eligible for along with a cost “per paycheck.” If at any point you would like to see more information, simply click on one of the menu items to the right of the screen to see expanded benefit summaries, forms, provider links, and more. After you’ve made your selection, click “continue” to go to the next benefit.
- 4) **Beneficiary Information:** It is important that you complete this information. You may select a dependent from the second screen, or you may designate any other person, organization, or estate trust. We recommend updating this information on an annual basis or after any major life event.
- 5) **Benefits Review:** This is the final step. Please review your benefit choices and costs. If you wish to make changes to your selections, click on the “Edit” button to update your information. Once you have completed your review, agree to the terms and hit “Continue.” You will then be given an opportunity to print a Benefits Confirmation Statement for your personal records.



WHEN CAN I ENROLL?

New Hires: You will have an opportunity to enroll during in processing. Benefits begin the first of the month following 30 days after the date of hire.

Open Enrollment: Open Enrollment is conducted annually during August and election changes are effective October 1. You may enroll and make changes online during this open enrollment season. Once open enrollment is closed, you may not make any changes to your benefit elections unless you experience a qualifying event.

If you experience a qualifying event during the plan year, you must request the appropriate changes from the Benefits Office within 30 days of the event. If you do not notify us within the 30 day time frame you will be required to wait until open enrollment to enroll or make changes.

Medical Benefits – Plan I (High Deductible-Health Plan with HSA)

Effective October 1, 2020

Here is a snapshot of the coverage offered through the 2020-21 medical plan(s). For a complete summary of medical benefits and coverage, refer to the medical page at www.mybensite.com/killeen. It is important to note that on this plan, co-insurance and co-pays (for prescriptions) do not apply until the deductible is met.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$2,800 Individual / \$5,600 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,600 Individual / \$13,200 Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-855-828-7715 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. An electronic referral is required to see a Network Specialist	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$10 copay Mail-Order: \$25 copay	Retail: \$10 copay Mail-Order: \$25 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply. *or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 copay Mail-Order: \$87.50 copay	Retail: \$35 copay Mail-Order: \$87.50 copay	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 copay Mail-Order: \$150 copay	Retail: \$60 copay Mail-Order: \$150 copay	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	Not Applicable	

Medical Benefits - Plan II

(Co-Pay)

Effective October 1, 2020

Here is a snapshot of the coverage offered through the 2020-21 medical plan(s). For a complete summary of medical benefits and coverage, refer to the medical page at www.mybensite.com/killen.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,500 Individual / \$10,500 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: \$8,150 Individual / \$16,300 Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-855-828-7715 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. An electronic referral is required to see a Network Specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: \$15 copay, deductible does not apply. Mail-Order: \$37.50 copay, deductible does not apply.	Retail: \$15 copay, deductible does not apply. Mail-Order: \$37.50 copay, deductible does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply. *or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 copay, deductible does not apply. Mail-Order: \$87.50 copay, deductible does not apply.	Retail: \$35 copay, deductible does not apply. Mail-Order: \$87.50 copay, deductible does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$70 copay, deductible does not apply. Mail-Order: \$175 copay, deductible does not apply.	Retail: \$70 copay, deductible does not apply. Mail-Order: \$175 copay, deductible does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	Not Applicable	

Wellness, What Does It Mean?

We are all being asked to become more involved with our well-being, to take a more active role in managing our health and spending resources wisely. Take charge of your health the same way we take charge of our other purchases.

- When you visit the grocery store, you compare cost, nutrition, and convenience as you decide what goes into the shopping cart.
- When you buy a car, you think about driving needs, safety and reliability, gas mileage, the dealer's markup, and what you are willing to pay.
- When you buy auto insurance, you think about your driving record and decide whether you prefer to pay a lower premium for a higher deductible or a higher premium for a lower deductible.

Think about how you can apply your shopping skills to your health.

- Learn and follow the recommended preventative care for your age and gender.
- Educate yourself about how diet and activity can affect your overall health or a specific chronic condition.
- Ask your doctor for an over-the-counter medication or generic version for your prescription.
- Compare cost and quality of doctors and hospitals in your area if you need to have surgery or a medical test.
- Make yourself aware of your individual health and take advantage of the options available to you.

Health care costs are rising. Costs can vary greatly between doctors, hospitals, pharmacies, and other facilities in the same local area; brand name, generic, and over-the-counter medications; and treatment options at the emergency room, urgent care center, and your doctor's office. The cost of your care does not necessarily equal the quality of care you receive.

In order to respond to the increasing cost of insurance benefits, in FY 2020-21 we will identify wellbeing opportunities that are intended to offset those costs while also improving our health. Those opportunities will focus on wellness and will include lunch and learns, financial workshops, and preventative care sessions (annual physicals, immunizations, health risk assessments, etc.). This is a collaborative work-in-progress; communicating these opportunities and the path forward will continue to be our priority, with more to come.



10 Ways to Save Money

- **Pharmacy:**
 - Use generics: They do the same job as brand name with a lower co-pay
 - Mail Order: Lower co-pays for medications you take regularly
 - Discount Programs: They offer prescriptions at a discounted price with or without insurance
- **Telemedicine or Urgent Care when appropriate vs. Emergency:**
 - Lower out-of-pocket costs
 - Less wait times
- **Quit Smoking:**
 - Package of cigarettes costs \$5.51 – Annual savings \$2,011.15
 - Enough to buy a vacation
- **Use In-network providers**
- **Lab work:**
 - Visit with your doctor about using participating facilities
- **Pre-tax Savings:**
 - Flexible Spending Account and Dependent Care Account
- **Read** your Explanation of Benefits (EOB) and doctor's bills
- **Go for regular check-ups:**
 - an ounce of prevention is worth a pound of cure
- **Join** wellness programs!
- **Healthy Rewards Discounts:**
 - free gym membership to the Lion's Club Park
 - weight loss programs,
 - vision



KNOW YOUR NUMBERS

Hopefully by now you know what your blood pressure, cholesterol, blood sugar, and BMI numbers are and if there are any risk factors. If not, now is the time to find out! In the coming year, you'll hear more about wellness screenings and how important they are to maintaining good health.

LDL Cholesterol (Bad Cholesterol)	
<100	Optimal
100-129	Near optimal/Above optimal
160-189	Borderline high
190+	Very high

HDL Cholesterol (Good Cholesterol)	
60+	Optimal, associated with lower risk for diabetes.
<40 men <50 women	Low; considered a risk factor for heart disease

Fasting Blood Sugar Level	
70 – 100 mg/dl	Optimal, associated with lower risk for diabetes.

Total Cholesterol Category	
<200	Desirable
200 – 239	Mildly High
240+	High

What is “Normal” Blood Pressure?	
A blood pressure reading has a top number (systolic) and bottom number (diastolic). The ranges are:	
<120 over 80 (120/80)	Normal
120 – 139 over 80 – 89	Pre-hypertension
140 – 159 over 90 - 99	Stage 1 high blood pressure
People whose blood pressure is above the normal range should consult their doctor about steps they can take to lower it.	

Body Mass Index	
Body mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.	
<18.5	Under weight
18.5 to 24.9	Normal
25.0 to 29.9	Overweight
30.0+	Obese

Medical Insurance Premiums

Medical/Dental Benefit Plans - Variable Contribution Rates					
<i>Plan Year (PY) 2020-21</i>					
	Premium	Employee Monthly Premium	Employer Monthly Cost	Employee Cost	
Medical					
Plan I (HDHP w/HSA)					
				w Wellness	w/o Wellness
Employee Only	\$376.06	\$0.00	\$376.06	\$0.00	\$50.00
Employee/Spouse	\$887.04	\$479.38	\$407.66	\$479.38	\$529.38
Employee/Children	\$541.66	\$157.12	\$384.54	\$157.12	\$207.12
Employee /Family	\$1,032.70	\$611.14	\$421.56	\$611.14	\$661.14
City HSA Contribution = \$ 112.75 per month					
Medical					
Plan II (Co-Pay)					
				w Wellness	w/o Wellness
Employee Only	\$480.32	\$25.00	\$455.32	\$25.00	\$75.00
Employee/Spouse	\$1,134.02	\$615.22	\$518.80	\$615.22	\$665.22
Employee/Children	\$692.48	\$220.04	\$472.44	\$220.04	\$270.04
Employee /Family	\$1,320.20	\$783.64	\$536.56	\$783.64	\$833.64



Dental Plan

Effective October 1, 2020

For a complete summary of medical benefits and coverage, refer to the dental page at www.mybensite.com/killeen.

The City of Killeen offers all eligible employees a dental plan through Lincoln Financial.

With the Dental PPO Plan through Lincoln Financial, you may see any dentist. However, in-network dentists have agreed to accept reduced fees for the services they provide.

If you receive services from an out-of-network dentist, benefits and reimbursement are based on the maximum allowable charges (MAC). The final reimbursement for out-of-network dentist will be based on the maximum allowable charges (MAC) of a network dentist. You may be responsible for the difference between out-of-network dentist billed charges minus the maximum allowable charges.

Here is a snapshot of the coverage offered.

LINCOLN DENTAL PLAN		LOW PLAN	HIGH PLAN
DEDUCTIBLE (Calendar Year)	Individual Family	\$50 \$150	\$50 \$150
ANNUAL BENEFIT MAXIMUM		\$1,250	\$3,000
PREVENTIVE SERVICES		100%	100%
BASIC SERVICES		80%	80%
MAJOR SERVICES		50%	50%
ORTHODONTIC SERVICES		50%; Lifetime Maximum \$1,000 to age 26	50%; Lifetime Maximum \$1,000 to any age

How to find a dentist

Visit lfg.com and in the Employee menu, select Dental.

The direct link is: <http://lfg.go2dental.com>



Dental Insurance Premiums

Medical/Dental Benefit Plans - Variable Contribution Rates					
Plan Year (PY) 2020-21					
	Premium	Employee Monthly Premium	Employer Monthly Cost	Employee Cost	
Dental Plans					
Low Plan (Orthodontia to age 26)					
Employee Only	\$24.70	\$0.00	\$24.70		
Employee/Spouse	\$49.32	\$24.62	\$24.70		
Employee/Children	\$54.06	\$29.36	\$24.70		
Employee /Family	\$84.02	\$59.32	\$24.70		
Dental Plans					
High Plan (Orthodontia any age)					
Employee Only	\$29.24	\$4.54	\$24.70		
Employee/Spouse	\$58.36	\$33.66	\$24.70		
Employee/Children	\$63.94	\$39.24	\$24.70		
Employee /Family	\$99.42	\$74.72	\$24.70		
Note: Rates based on monthly amount.					

Note: Rates shown are the monthly amount.



Basic Life/Accidental Death and Dismemberment (AD&D)

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you pass away while employed by the City of Killeen. As an eligible employee, you are covered for Base Life and Accidental Death and Dismemberment (AD&D) insurance at **no cost** to you.



Group Term Life Insurance Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: **City of Killeen**

Coverage

Life	\$15,000
Guarantee Issue	\$15,000
AD&D	Will Equal the Life Benefit

Benefit Termination

Employee

Benefits will terminate: Benefits terminate at retirement

Additional Benefits

See Understanding Your Benefits Page:	Accelerated Death Benefit Conversion Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Continuation of Coverage Accident Plus
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Enrolling for Coverage

Eligibility: All employees in an eligible class.

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Not for use in New York.

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Basic Life/Accidental Death and Dismemberment (AD&D)

Understanding Your Benefits

Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Continuation of Coverage	If coverage has been in force for at least 12 months, you may continue your coverage for a specified period of time after your employment by paying the required premium. Continuation of coverage is available if you cease employment for a reason other than sickness, injury, or retirement.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit - Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs due to the accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Accident Plus	If loss occurs due to an accident, you may also receive the following Accident Plus benefits: Coma, Plegia, Repatriation, Education, Spouse Training, and Child Care. Refer to your certificate for more details.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Additional Benefits

LifeKeysSM

Online will & testament preparation service, identify theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.

TravelConnectSM

Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at

(800) 423-2765; reference ID: **KILLEENTX**

www.lincolnfinancial.com



GROUP BENEFITS

Real life, real support

Helpful resources; confidential counseling

*EmployeeConnect*SM services

Life brings challenges. *EmployeeConnect* delivers help.

Everyone needs help solving problems sometimes. *EmployeeConnect* offers confidential assistance to help you and your family meet the challenges that life, work and relationships can bring.

Get help 24/7 with:

Depression

Substance abuse

Legal and financial concerns

Marital or family difficulties

Stress management/anxiety

Child or elder care

Who is eligible?

You and your immediate household family members are eligible to access *EmployeeConnect* services as part of your long-term disability coverage from Lincoln.

What services can I access?

- Unlimited, 24/7 toll-free phone and online access to:
 - Family and personal convenience information and referrals for topics such as child and elder care, kennels and pet care, vacation planning, relocation, car buying and colleges
 - Legal information and referrals for situations requiring expertise in family law, estate planning, landlord/tenant relations, consumer and civil law, and more
 - Financial information and referrals to assist with concerns such as household budgeting, as well as short- and long-term planning
- In-person help for short-term issues; up to four* sessions with a counselor per person, per issue, per year
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and subsequent meetings at a reduced fee
- Web-based resources
 - Articles
 - Tutorials
 - Streaming videos
 - Interactive tools and assessments such as financial calculators, budgeting spreadsheets and a language translator
- Customized information packets to accompany all work-life services

* In California, up to three sessions in six months, starting with initial contact by employee.

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Vision Benefits

Effective October 1, 2020

This is a snapshot of the coverage offered through the 2020-21 benefit year. For a complete summary of vision benefits and coverage, refer to the additional benefits page at www.mybensite.com/killen.

Your vision health is an important part of complete wellness. Guardian is pleased to present your vision benefits which are designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

VISION PLAN	BASE PLAN	BUY-UP PLAN
Exam/ Materials	\$10/\$0	\$10/\$0
Frames Allowance	\$150 Retail	\$150 Retail
Single Lenses	Covered in Full	Covered in Full
Bi Focal Lenses	Covered in Full	Covered in Full
Tri Focal Lenses	Covered in Full	Covered in Full
Scratch & UV Protection	\$17 / \$15	Covered in Full
Basic Progressive Lenses	\$75	Covered in Full
Advanced Progressive Lenses	\$110 and up	\$120 Allowance + 20%
Elective Contacts Allowance	\$150	\$150
Fitting Exam	\$50/\$75	\$50/\$75
Necessary Contacts	\$250	\$250
	Out of Network	Out of Network
Exam Allowance	\$59	\$59
Frames Allowance	\$70	\$70
Single Lenses Allowance	\$30	\$30
Bi Focal Lenses Allowance	\$50	\$50
Tri Focal Lenses Allowance	\$65	\$65
Progressive Lenses Allowance	\$50	\$50
Elective Contacts Allowance	\$120	\$120
Necessary Contacts Allowance	\$210	\$210

BENEFIT FREQUENCY		RATES		
Benefit	Frequency	Plan Tier	Base	Buy-Up
Vision Plan	12 Months	Employee Only	\$5.34	\$9.80
Spectacle Lenses	12 Months	Employee + Spouse	\$9.36	\$17.28
Contact Lenses	12 Months	Employee + Child(ren)	\$11.32	\$19.98
Frames	24 Months	Employee + Family	\$13.90	\$25.84

Vision Benefits (continued)

Manage Your Benefits

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.GuardianAnytime.com.

Find a Vision Provider

Visit www.GuardianAnytime.com. Click “Find A Provider” and select Guardian Vision as your vision plan.

Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Guardian Vision for reimbursement. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Guardian Vision provider. Out-of-network claim forms can be obtained by contacting Guardian Vision Customer Response Unit or your group administrator, or by visiting www.GuardianAnytime.com.

Limitations and Exclusions

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Copays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. See Certificate Booklet for details.

Laser Correction Surgery

Laser surgery is not an insured benefit unless noted in your Certificate Booklet. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Termination Provisions

Coverage will end on the earliest of: the date the policy ends, the date the employee’s employment ends, or the date the employee is no longer eligible.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed and may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Guardian is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart, Sam’s Club or Costco locations. Members may not use their contact lens allowance toward fitting fees, when covered at Walmart, Sam’s Club, or Costco and are responsible for any out-of-pocket fees associated with fittings there. ID cards are not required for services.

Important Information

Guardian Website: www.GuardianAnytime.com
Customer Service Number: 1-844-557-2646 | 8:00am – 9:00pm EST
LASIK Provider Number: 1-877-712-2010

Voluntary Life & Accidental Death and Dismemberment Benefits

In addition to the Basic Life/AD&D benefit provided to you by the City of Killeen, you may purchase voluntary Life/AD&D insurance for yourself and/or your eligible dependents, through Lincoln Financial. In order to purchase voluntary Life/AD&D insurance for dependents, you must purchase voluntary life coverage for yourself.

If this is your initial enrollment period, you may elect up to the guarantee issue amount without providing evidence of insurability (EOI). If you previously waived coverage, you will be required to complete an EOI form regardless of the amount of coverage you select. Coverage will not become effective until and unless approved by Lincoln Financial.

LINCOLN FINANCIAL	VOLUNTARY LIFE AND AD&D
EMPLOYEE OPTION	\$10,000 increments up to 7 times salary or a maximum of \$500,000 Open enrollment period: Policies may be increased in \$10,000 increments up to two (2) increments
NEW EMPLOYEE GUARANTEE ISSUE AMOUNT	\$250,000
SPOUSE OPTION	\$5,000 increments up to \$250,000 not to exceed 50% of the employee's benefit amount
SPOUSE GUARANTEE ISSUE AMOUNT	\$75,000
CHILD(REN) OPTION	\$5,000 or \$10,000, (guarantee issue \$10,000)

Voluntary Short Term Disability (STD) – Lincoln

Voluntary Short Term Disability (STD) is designed to replace a portion of your weekly earnings due to sickness or injury. To prevent over-insurance, benefit payments are reduced by deductible sources of income. This coverage offer is through Unum.

LINCOLN	VOLUNTARY SHORT TERM DISABILITY
BENEFIT PERCENTAGE	60% of Your Basic Weekly Earnings
MAXIMUM WEEKLY BENEFIT	\$2,500
ELIMINATION PERIOD (Injury/sickness)	Option 1: 7/7 Days Option 2: 14/14 Days
DURATION OF BENEFITS	Option 1: 25 Weeks Option 2: 24 Weeks
PRE-EXISTING CONDITION LIMITATION	3 months prior/12 months after effective date

Voluntary Long Term Disability (LTD) – Lincoln

Voluntary Long Term Disability (LTD) is designed to replace a portion of your weekly earnings due to sickness or injury. To prevent over-insurance, benefit payments are reduced by deductible sources of income. This coverage offer is through Unum.

LINCOLN	VOLUNTARY LONG TERM DISABILITY
BENEFIT PERCENTAGE	60% of Your Basic Weekly Earnings
MAXIMUM WEEKLY BENEFIT	\$10,000
ELIMINATION PERIOD (Injury/sickness)	180 Days
DURATION OF BENEFITS	up to Social Security normal retirement age
MENTAL ILLNESS LIMITATION	2 years
SUBSTANCE ABUSE LIMITATION	2 years
PRE-EXISTING CONDITION LIMITATION	12 months prior/12/24 months after effective date

Please refer to Summary of Benefits for complete benefits and coverage.

Accident Plan – Lincoln Financial

Accident plan provides coverage and pays for charges when medical treatment is required as a result of an accidental bodily injury. Please refer to Summary of Benefits for complete benefits and coverage.

Benefit Type	Choice Plan	Preferred Plan
EMERGENCY CARE		
Ambulance	\$150	\$250
Air Ambulance	\$600	\$1,200
Initial Physician Office Visit	\$75	\$100
Emergency Room	\$150	\$170
Major Diagnostic Care	\$100	\$200
TREATMENT CARE		
Hospital Admission	\$1,000	\$1,300
Hospital Confinement daily benefit	\$200	\$250
Intensive Care unit daily benefit	\$400	\$600
Alternate care and rehabilitative facility daily benefit	\$100	\$130
Follow-up doctor/patient care up to 6 sessions	\$50	\$50
Transportation for care (up to 3 times per accident)	\$300	\$450
Companion lodging (up to 30 days per accident)	\$100	\$130
Family care per child up to 30 days	\$20	\$25
FRACTURES (per fracture)	Non-Surgical/Surgical	Non-Surgical/Surgical
Ankle, arm, collarbone, elbow, foot, hand, jaw	\$600/\$1,200	\$1,000/\$2,000
Hip	\$2,800/\$5,600	\$3,400/\$6,800
Skull (depressed)	\$2,500/\$5,000	\$3,000/\$6,000
Leg, pelvis, skull non-depressed, vertebral column	\$1,500/\$3,000	\$1,800/\$3,600
Bones of face, vertebrae, coccyx, rib, nose	\$450/\$900	\$600/\$1,200
Finger, toe	\$100/\$200	\$250/\$500
Chip Fracture	25% of fracture benefit	25% of fracture benefit
DISLOCATIONS (per injury)	Non-Surgical/Surgical	Non-Surgical/Surgical
Ankle, collarbone, sternoclavicular, foot	\$800/\$1,600	\$1,000/\$2,000
Collarbone acromio and separation, elbow, hand	\$500/\$1,000	\$800/\$1,600
Finger, toe	\$150/\$300	\$300/\$600
Hip	\$2,400/\$4,800	\$3,000/\$6,000
Knee, except kneecap	\$1,500/\$3,000	\$1,800/\$3,600
Partial dislocation	25% of dislocation benefit	25% of dislocation benefit
ACCIDENTAL DEATH AND DISMEMBERMENT		
Employee	\$75,000	\$100,000
Spouse	\$25,000	\$50,000
Child	\$12,500	\$25,000
Common Carrier enhance death benefit	2 X Benefit Amount	2 X Benefit Amount
Catastrophic loss	\$50,000	\$80,000

Critical Illness Insurance – Lincoln Financial

Surviving a critical illness is becoming more common today, thanks to advances in medicine. With Critical Illness insurance benefits from Lincoln Financial Group, you can face your financial future with confidence and concentrate on getting better when one strikes. You have the option of purchasing coverage in increments of \$10,000 to \$20,000. The benefit you receive depends on the condition and the percentage of the principal sum.

Lincoln Financial	Plan Benefit
MAXIMUM PRINCIPAL SUM	
Employee	\$20,000
Spouse	\$10,000
Child	\$10,000
GUARANTEE ISSUE AMOUNT	
Employee	\$20,000
Spouse	\$10,000
Child	All Guarantee Issue
HEALTH SCREENING	
Employee	\$50
Family (per dependent)	\$25
HEART CATEGORY	Percent of Principal Sum
Heart Attack	100%
Transplant	100%
Stroke	100%
Arteriosclerosis	10%
Aneurysm	10%
ORGAN CATEGORY	Percent of Principal Sum
End Stage Renal Failure	100%
Major Organ Transplant (excluding heart)	100%
Acute Respiratory Distress Syndrome	25%
OTHER CATEGORIES (Partial List, see Benefit Summary for complete list)	Percent of Principal sum
Severe Burn	100%
Coma	100%
Loss of Hearing	25%
Loss of Sight	25%
CANCER CATEGORY	Percent of Principal Sum
Invasive Cancer	100%
Cancer In Situ	25%
Benign Brain Tumor	25%
Bone Marrow Transplant	25%
PRE-EXISTING CONDITION	12/12

Example: I buy \$10,000 in coverage and then have stroke. I get paid \$10,000. Alternatively, if I have an aneurysm I get paid 10% of the \$10,000 or \$1,000.

Cancer Insurance – Guardian

Did you know on average out-of-pocket cost for cancer care is more than \$1,200 per month? Cancer insurance can help by supplementing your medical benefit and disability income insurance. It provides a cash benefit to you based off the treatments you received related to a covered cancer diagnosis. The benefit payment to you is in addition to your medical insurance.

Guardian	Advantage Plan	Premier Plan
INITIAL DIAGNOSIS Benefit Amount (s) Employee Spouse Child Waiting Period	\$2,500 \$2,500 \$2,500 30 Days	\$5,000 \$5,000 \$5,000 30 Days
CANCER SCREENING	\$75	\$75
HOSPITAL CONFINEMENT	\$300/Day (1st 30 Days) \$600/Day (31 days+)	\$400/Day (1st 30 Days) \$800/Day (31 days+)
ICU CONFINEMENT	\$400/Day (1st 30 days) \$600/Day (31 days+)	\$600/Day (1st 30 days) \$800/Day (31 days+)
FEATURES (Partial List, see Benefit Summary) Ambulance Anesthesia Surgical Benefit Transportation	\$200/Trip, limit 2 per confinement 25% of surgery benefit Schedule up to \$4,125 \$0.50/mile up to \$1,000 per round trip/equal benefit for companion	\$250/Trip, limit 2 per confinement 25% of surgery benefit Schedule up to \$5,500 \$0.50/mile; Up to \$1,500 per round trip/equal benefit for companion
WAIVER OF PREMIUM	Included	Included
PRE-EXISTING CONDITION	6 months prior/ 12 months treatment free/ 24 months after	6 months prior/ 12 months treatment free/ 24 months after

Combined Insurance

LifeTime Benefit Term – Champion

Life Insurance with money for long term care

Life Insurance—Powerful protection for your loved ones

You work hard to provide a good life for your family. However, what if something happens to you? If they need you, you need a champion to help defend and protect your family with money to help pay for:

- Rent and mortgage
- College education
- Retirement
- Household expenses

Make a promise to help protect the future. Let LifeTime Benefit Term (LBT) be your Champion. It lasts a lifetime—guaranteed. LifeTime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living, or nursing care. Lifetime Benefit Term provides competitive rates and benefits and lasts to age 121.

- Long term care
- Childcare
- Family debt
- Burial

Innovative Benefit Design

Guaranteed Premiums

Premiums for the life base insurance will never increase and are guaranteed through age 100.

Guaranteed Benefits during Working Years

Death Benefit is guaranteed 100% when it is needed most—during your working years when your family is relying on your income. Through age 70 (or 25 years if greater), your death benefit is 100% guaranteed.

Guaranteed Benefits After Age 70

Even after age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50%. Based on current interest rates, the full death benefit is designed to last a lifetime.

Paid-up Benefits

After 10 years, paid up benefit begin to accrue. At any point thereafter, if premiums stop, a reduced paid up benefit is guaranteed. Flexibility is perfect for retirement.

Long Term Care (LTC)*

If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. After the required elimination period, you get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Contingent Benefit

If your LTC rider premiums were to be increased and would cause you to lapse your coverage within 120 days of an increase, you may reduce your benefit amount without any increase in premium or convert LTC coverage to paid up status equal to 100% of all LTC rider premiums paid, or 30 times the daily nursing home benefit allowed under the LTC rider.

Combined Insurance (continued)

Here's how LifeTime Benefit Term can help be Your Family's Champion

As Life Insurance

LifeTime Benefit Term helps protect your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long Term Care

If you become chronically ill, your LifeTime Benefit Term policy will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. Your life insurance will continue to help you protect your assets for 25 months. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.

For Terminal Illness

You can receive 50% of your death benefit immediately, up to \$100,000, if you are diagnosed as terminally ill.

Strong Guarantees

Life insurance provides your family with money after your death. It helps replace your income and ensure that your dependents are not burdened with debt.

Features

Strong Guarantees

Guaranteed life insurance Premium* and Death Benefits last a lifetime.

Fully Portable and Guaranteed Renewable* for Life

Your coverage cannot be cancelled as long as premiums are paid as due.

Family Coverage

Coverage available for your spouse, children and dependent grandchildren.

* LTC premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums cannot be increased solely because of an independent claim. New premiums will be based on the Insured's age and premium class on the rider's coverage date. Guaranteed life insurance Premium* and Death Benefits.

LifeTime Benefit Term Exclusions

If the insured commits suicide, while sane or insane, within two years from the Date of Issue, and while this Coverage is in force, we will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Combined Insurance (continued)

Long Term Care Exclusions

We will not pay Long Term Care benefits for care that is received or loss incurred as a result of:

1. Mental or nervous conditions except Alzheimer's Disease;
2. Alcoholism and drug addiction;
3. Illness, treatment or medical conditions arising out of;
 - a. War or act of war (whether declared or undeclared);
 - b. Participation in a felony, riot or insurrection;
 - c. Service in the armed forces or units auxiliary thereto;
 - d. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
 - e. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other Governmental program (except Medicaid), any state or federal workers' compensation, employers' liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.
4. Expenses for services or items available or paid under another long term care insurance or health insurance policy.
5. In the case of a qualified long term care contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act; or would be so reimbursable but for the application of a deductible or coinsurance amount; or
6. Care or services received outside the United States or its territories.



LifeTime Benefit Term is a great way to help protect your most important asset and help provide the peace of mind your family deserves.

Flexible Spending Account

Effective October 1, 2020

This is a snapshot of the coverage offered through the 2020-21 benefit year. For a complete summary of the Flexible Spending Account and coverage refer to the additional benefits page at www.mybensite.com/killeen.

The flexible spending plan is offered through Discovery Benefits. A flexible Spending Account (FSA) can provide an important tax advantage that allows you to pay certain health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the Health Care Reimbursement FSA is \$2,750. Some examples include:

- Deductible, Prescriptions, and Doctor Visit Co-Payments
- Over-the-Counter Medicines with a Prescription
- Vision services, including Lasik Eye Surgery, Glasses, and Contacts
- Hearing services, including hearing aids and batteries
- Orthodontics, Dental deductibles and coinsurance
- Acupuncture

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars towards qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$5,000 for 2020-20, (or \$2,500 if married and filing separately).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

FSA Smart Tips

- Cover any significant medical expenses early in the year using your FSA. You'll spend the remainder of the year paying yourself back with the regular payroll deductions.
- Save your receipts as proof of purchase in order to be reimbursed for your health care expenses from your FSA. So if you are making purchases that are eligible for reimbursement, you'll want to keep them separate from other items.
- Take advantage of the pre-tax savings and use your FSA dollars. Remember, unused money in an FSA at the end of the year is lost.

For more information on the FSA plan(s), please visit www.discoverybenefits.com.

Health Savings Account (HSA)

Effective October 1, 2020

A HEALTH SAVINGS ACCOUNT: THE TRIPLE TAX ADVANTAGE BENEFIT

Health care expenses are a growing concern for many—and a Discovery Benefits health savings account, or HSA, is an option becoming increasingly available to help workers set money aside. And there are tax benefits of an HSA as well. In fact, a health savings account offers account owners a triple tax advantage:

- Contributions reduce taxable income.
- Earnings on the account build up tax free.
- Distributions from the account for HAS qualified expenses aren't subject to taxation.

Eligibility is set by different guidelines specific to this type of account. A health savings account allows those enrolled in high-deductible health plans (HDHPs) to save money tax-free to pay for medical expenses. Unlike a flexible spending account (FSA), a health savings account can be used as an investment account because the funds aren't lost after a certain period of time.

The benefits of an HSA share a lot of similarities with individual retirement accounts (IRAs), such as:

- Allows employees to save and grow money, tax-free.
- Employees can decide how to invest and grow their money.
- Funds can be withdrawn anytime for medical expenses.
- After age 65, the funds can be used for any purpose, without penalty.

There are two types of health savings account offerings from Discovery Benefits:

EMPLOYER-SPONSORED HSA

An employer offers a HDHP combined with an HSA.

How it Works

1. An employee enrolls.
2. Money is deducted from the employee's paycheck to go toward health savings. Employers can also make contributions.
3. The employee manages their own funds and investment options.
4. The health savings account is used to pay for out-of-pocket medical expenses that are eligible for reimbursement.

INDIVIDUAL HSA

Individuals enrolled in HDHPs can open their own account for health savings, similar to how they might open traditional checking or savings accounts.

How it Works

1. Individuals enroll.
2. Money is automatically deposited into the account from the individual's bank account.
3. The individual manages funds and [investment options](#).
4. The account is used to pay for out-of-pocket medical expenses that are [eligible for reimbursement](#).

THE BENEFITS OF HSA ADMINISTRATION WITH DISCOVERY BENEFITS

- **Flexibility.** As a leading HSA administrator, Discovery Benefits offers participants a number of convenient payment options for their health savings expenses. Submit a pay-the-provider request online and payment is sent directly to the healthcare provider within 2-3 business days. Or select the Claims Sync option and easily monitor your incoming insurance claims; find one that needs

payment and simply click submit. The Benefits Debit Card is available at your fingertips as well for point-of-service payment.

- **One Card.** Everyone is looking for simple. One of the benefits of opening an account with Discovery Benefits is that we use the same Benefits Debit Card for all products. Participants enrolled in multiple plans like that the process is streamlined and they can use the same card. The card's technology ensures the correct balance is pulled when they run their card. Need to order more cards for your spouse or child? No problem, and no charge.
- **Integration.** Discovery Benefits understands strong integrations with our clients' other partners saves everyone time and stress in the set-up process and on-going administration of our products. Discovery Benefits has become a true industry leader in HSA administration with our ability to integrate with our clients' platforms and technologies.



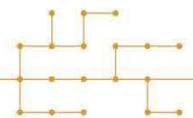
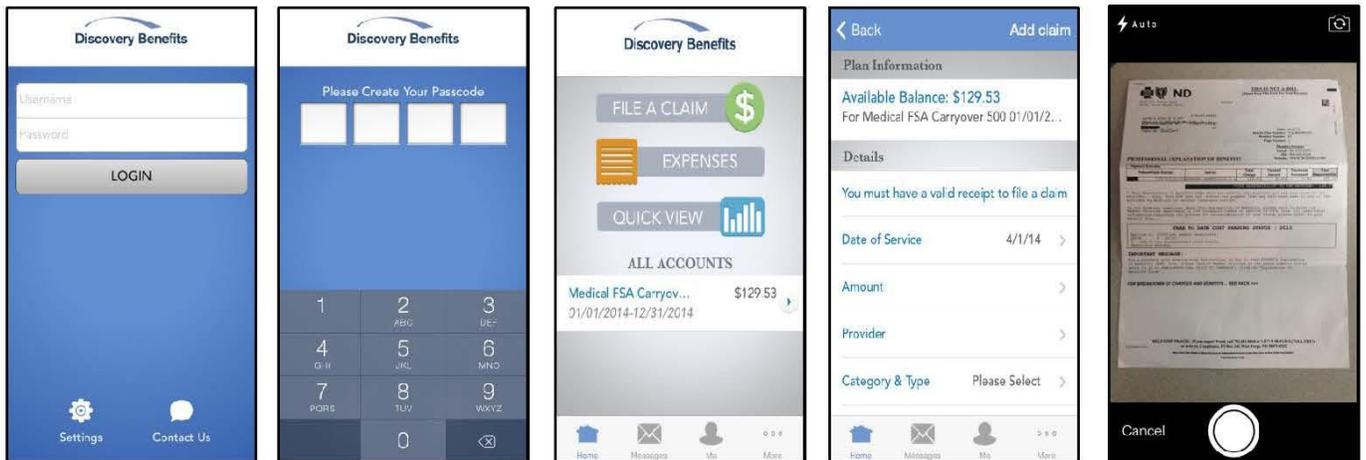
The Discovery Benefits Mobile Application

Check out the Discovery Benefits Mobile Application for iPhone, iPad and Android devices. It's never been easier or more convenient to access your account information. Our App allows you to upload receipts, check your balances, view final filing dates, access claim detail, contact customer service, report a lost or stolen debit card, reset your password and even file a claim.

The data transfer is secure as we utilize 128-bit SSL on all mobile transmissions and a passcode is required each time you enter the App. No pictures are stored on the phone, so you can rest assured that your information is safe.

The Discovery Benefits Mobile Application will simplify how you use your Flexible Spending Account, Health Savings Account, Parking/Transit Account or Health Reimbursement Arrangement. Get the App today - available FREE in the iTunes Store and Google Play Store.

Upload Receipts - Check Balances - File Claims - View Filing Dates - Contact Us - Secure Transmission



457 Deferred Retirement Account

ICMA

A 457 deferred compensation plan allows you to save and invest money for retirement with tax benefits.

Contributions are made to an account in your name for the exclusive benefit of you and your beneficiaries. The value of the account is based on the contributions made and the investment performance over time.

A 457 plan is designed to supplement your retirement income. While a pension and/or Social Security may go a long way, they are unlikely to be enough. Saving to your 457 plan can help you maintain your desired standard of living.

Contributions

Pre-tax contributions you make reduce your taxable income for the year. These contributions and all associated earnings are then not subject to tax until you withdraw them. You also may be able to make after-tax Roth contributions which allow for potentially *tax-free* earnings.

Contribution limits apply – for 2020, you can contribute up to \$25,000 if you are age 50 or over, or up to \$37,000 if you qualify for pre-retirement catch-up contributions. Otherwise the regular annual limit for 2020 is \$19,000.

To contribute to your 457 plan or change the amount of your current contributions, contact your employer or your ICMA-RC representative for instructions, including whether you can submit these completed ICMA-RC forms to your employer:

- 457 Plan Enrollment Form - to participate for the first time.
- Contribution Change Form - to resume contributions if you previously enrolled, or to increase or decrease current contributions.

Investments

You control how your account is invested, choosing from options selected by your employer.

A typical plan includes a wide range of options, from more conservative stable value funds and CDs to more aggressive bond and stock funds. You may choose to build a diversified portfolio of various funds, select a simple yet diversified target-date or target-risk fund, or rely on specific investment advice through Guided Pathways.

- To review investment options for your plan, login to your account.
- To learn more about investing for retirement, visit www.icmarc.org/invest.

Withdrawals

You can make withdrawals from your account when you leave employment. You have the ability to take payments as needed or request scheduled automatic payments. You maintain control over your investments and continue to benefit from tax deferral even after you leave your employer. During employment, subject to your employer and IRS rules, you may also be able to make withdrawals after age 70½ or due to an unforeseeable emergency. A loan option may also be available.

Withdrawals are generally taxable but, unlike other retirement accounts, the 10% penalty tax does not apply to distributions prior to age 59½ (the penalty tax may apply to distributions of assets that were transferred to the 457 plan from other types of retirement accounts). For detailed tax information, view Special Tax Notice Regarding Plan Payments.

457 Deferred Retirement Account (continued)

Have a plan for taking withdrawals from your account - both to manage the tax bill and to provide for your future needs. For guidance, view Making a Smart Withdrawal Decision, and our RealizeRetirement website, or contact your ICMA-RC representative.

To request a withdrawal from your ICMA-RC account:

- Log in to your account to see if your employer allows online withdrawals. Select Withdraw Funds from the left-hand menu.
- Or, complete and submit the forms in the 457 Plan Benefit Withdrawal Packet. To obtain a copy, contact Investor Services.

Survivor Benefits

You designate a beneficiary, or beneficiaries, to receive any remaining assets upon your death. Designating beneficiaries can help ensure your assets are paid per your wishes, avoid the potential costs and delays of probate, and allow non-spouse beneficiaries to receive additional tax benefits.



NATIONWIDE

Deferred compensation plans, also known as 457 retirement plans are designed for state and municipal workers and employees of some tax-exempt organizations.

If you participate in a 457 plan, you can contribute a portion of your salary to a retirement account. That money and any earnings you accumulate are not taxed until you withdraw them.

With a 457 retirement savings plan:

- There isn't a minimum retirement age
- There isn't a 10% federal penalty for early withdrawal of funds, although withdrawals are subject to ordinary income taxes
- There is a withdrawal option for unforeseen emergencies that meet certain legal criteria, if all other financial resources are exhausted

Distributions are available in a lump sum, annual installments or as an annuity. There is no tax withholding if you leave for a new job and roll over your money into an IRA or your new employer's 401(k), 403(b) or 457 plan – or if you take regular installments for 10 years or more. (All other distributions are subject to 20% withholding for federal taxes.)

Keep in mind that federal income tax laws are complex and subject to change. Neither Nationwide nor our representatives give legal or tax advice. Please consult your attorney or tax advisor for answers to specific questions.



What Constitutes a Qualifying Life Event?

Qualifying Life Event	Medical	Dental	Suppl EE Life	Suppl Spouse Life	Suppl Child Life	FSA Medical	FSA Dependent Care	Beneficiaries	
Change in marital status: <ul style="list-style-type: none"> • Marriage • Divorce or Annulment • Legal Separation • Death of Spouse 	✓	✓		✓		✓	✓	✓	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certification
Change in the number of dependents: <ul style="list-style-type: none"> • Birth • Adoption • Guardianship of a Child • Death of a Dependent 	✓	✓			✓	✓	✓	✓	Birth Certificate Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Becomes Eligible	✓	✓	✓	✓	✓	✓	✓	✓	Provide Name, Social Security Number, and Date of Birth for dependents
Dependent Loses Other Coverage	✓	✓				✓	✓	✓	Proof of Loss of Coverage, such as termination letter; Certificate of Credible Coverage
Dependent Gains Other Coverage	✓	✓				✓	✓	✓	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's, or dependent's work hours (including a switch between full and part-time status)	✓	✓				✓	✓	✓	Proof of loss of Coverage due to employment status change, such as Certificate of Credible Coverage or letter from the company
Change in Dependent Care Costs							✓		Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	✓	✓			✓	✓	✓	✓	Contact your Benefits Team Directly

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA) requires a group health plan to provide a Notice of Special Enrollment Rights annually to all employees who are eligible to participate in the plan.

Notice of Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

The **City of Killeen Group Health Plan** will allow an employee or dependent who is eligible, but not enrolled, for coverage to enroll for coverage if either of the following events occur:

Medicaid Coverage:

1. **TERMINATION OF MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE-** If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP-** If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 30 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Human Resources Department.

Annual Notices (continued)

Health Insurance Portability and Accountability Act (HIPAA)

The City of Killeen in accordance with HIPAA, protects your Protected Health Information (PHI). The City of Killeen will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

HIPAA Privacy Notice Update

HIPAA requires The City of Killeen to notify you that the Privacy Notice is available from the HR Department. To request a copy of the City of Killeen's Privacy Notice or for additional information, please contact the HR Department.

Pre-Tax Contributions

In most cases, the City of Killeen employees' contributions for medical and dental coverage's are deducted from their paychecks on a pre-tax basis, meaning before federal income tax is calculated. Internal Revenue Code (I.R.C.) Section 152 defines what dependent contributions are eligible for pre-tax deductions. The IRS does not allow employees' contributions for dependent health coverage to be deducted on a pre-tax basis unless the dependent(s) meet the definition of a tax dependent under I.R.C. Section 152. If they do not meet the definition of a tax dependent, they may be either ineligible for the Plan, or in some cases, the IRS taxes the additional fair market value of these benefits and treats it as Imputed Income. Contributions for medical, dental and vision coverage for eligible dependents that do not meet the definition of a tax dependent will be made on a post-tax basis and the Imputed Income will be included on your paycheck and IRS Form W-2.

Newborn's and Mother's Health Protection Act

Federal law (Newborn's and Mother's Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year.

Annual Notices (continued)

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymph edemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and co-pays consistent with other coverage provided by the Plan.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) applies to the City of Killeen Group Health Plan. This new law establishes a basic, uniform national standard to protect the public from discrimination based on genetic information.

Continuation Required by Federal Law for You and Your Dependents

Federal law enables you or your dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact the Human Resources Department.



Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP

Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfnv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/pi/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services

Employee Benefits Security Administration

Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa

www.cms.hhs.gov

1-866-444-EBSA (3272)

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44

U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Medicare Part D Notice

IMPORTANT NOTICE FROM THE CITY OF KILLEEN ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Killeen and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Killeen has determined that the prescription drug coverage offered by the City of Killeen is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The City of Killeen coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health benefits.

If you do decide to join a Medicare drug plan and drop your current The City of Killeen coverage, be aware that you and your dependents may not be able to get this coverage back.

Medicare Part D Notice (continued)

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with The City of Killeen and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Killeen changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ⇒ Visit www.medicare.gov
- ⇒ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- ⇒ Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1.800.772.1213 (TTY 1.800.325.0778)**

Name of Entity:	The City of Killeen
Contact:	Compensation and Benefits Manager
Address:	718 N. 2nd Street, Bldg H Suite B Killeen, Texas 76541
Phone Number:	254-501-7837



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City		8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

2020-21 Benefit Guide

also available online at:

- The City of Killeen Public Drive
Public Drive/Human Resources/Benefits 2020-21
- City of Killeen website
Human Resources Department
www.killeentexas.gov
- Web Benefit Design website
www.mybensite.com/killeen

The information contained in this enrollment guide is an outline of the coverage offered by the City of Killeen Group Health Plan. It does not include all of the terms, exclusions, limitations and conditions of the actual language. If there is a conflict between the information in this guide and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents. Plan documents or policies will be made available for review upon request. The City of Killeen Group Health Plan reserves the right to modify, amend, suspend or terminate any plan at any time for any reason.